ORIGINAL ARTICLE

Counter-referral: strategy for continuity of care in the health of women and newborns

Contrarreferência: estratégia para continuidade do cuidado na saúde da mulher e recém-nato

Contrarreferencia: estrategia para la continuidad de la atención en salud de la mujer y el recién nacido

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ABSTRACT

Objective: to evaluate counter-referral as a strategy for the continuity of care of women and newborns from a usual-risk maternity hospital to primary health care. **Methods:** qualitative study developed in a usual-risk maternity and in health units in Curitiba, Paraná, Brazil. Data collection period was between September and November 2020 with nurses from the health units and women who had counter-referral discharge from the maternity hospital. After content analysis, the speeches were divided into themes and subthemes predefined by the theoretical framework adopted, which provides for three categories of continuity of care and their respective dimensions. **Results:** eight nurses and six puerperal women participated. Twenty-six strata emerged from the interviews. Highlights, in the Informational category, the dimension "the use of information obtained by counter-referral for continuity of care"; in the Relational category, the dimension "the importance of professional-patient bonding", and in the Managerial category, "the use of network mechanisms for effective care". **Conclusion:** the counter-referral was evidenced as a strategy for continuity of care by the two groups investigated, capable of providing support to promote efficient care for puerperal women. However, there is a need to optimize standardized counter-referral instruments, making the process effective in the health network.

Descriptors: Continuity of Patient Care; Healthcare Coordination and Monitoring; Health Services Administration; Maternal-Child Health Services; Nursing.

RESUMO

Objetivo: *avaliar a contrarreferência como estratégia para a continuidade do cuidado às mulheres e recém-nascidos de uma maternidade de risco habitual para a atenção primária de saúde.* ***Métodos:*** *estudo qualitativo realizado em maternidade de risco habitual e em unidades de saúde em Curitiba, Paraná, Brasil. Os dados foram coletados entre setembro e novembro de 2020, com enfermeiros das unidades de saúde e mulheres que tiveram a alta contrarrefenciada da maternidade. Mediante análise de conteúdo, as falas foram estratificadas em temas e subtemas pré-definidos pelo referencial teórico adotado, que prevê três categorias de continuidade do cuidado e suas respectivas dimensões.* ***Resultados:*** *participaram oito enfermeiros e seis puérperas. Emergiram das entrevistas 26 estratos. Destacaram-se, na Categoria informacional, a dimensão "o uso das informações obtidas pela contrarreferência para continuidade do cuidado"; na Categoria relacional a dimensão "a importância de vínculo entre profissionais e pacientes", e na Categoria gerencial "a utilização de mecanismos de rede para um cuidado efetivo".* ***Conclusão:*** *a contrarreferência foi evidenciada como estratégia para continuidade de cuidado pelos dois grupos investigados, capaz de proporcionar subsídios para promover um cuidado eficiente para as puérperas. Entretanto, há necessidade de otimizar instrumentos de contrarreferência padronizados, efetivando o processo na rede de saúde.*

Descritores: *Continuidade da assistência ao paciente; Regulação e fiscalização em saúde; Administração de serviços de saúde; Serviços de Saúde Materno-Infantil; Enfermagem.*

RESUMEN

Objetivo: *evaluar la contrarreferencia como estrategia para la continuidad de la atención a mujeres y recién nacidos en una maternidad de riesgo habitual para la atención primaria de salud.* ***Métodos:*** *estudio cualitativo desarrollado en maternidades de riesgo habitual y en unidades de salud de Curitiba, Paraná, Brasil. El período de recolección de datos fue entre septiembre y noviembre de 2020 con enfermeros de las unidades de salud y mujeres que tuvieron alta por contrarreferencia de la maternidad. A través del análisis de contenido, los discursos fueron divididos en temas y subtemas predefinidos por el referencial teórico adoptado, que prevé tres categorías de continuidad del cuidado y sus respectivas dimensiones.* ***Results:*** *eight nurses and six puerperal women participated. Twenty-six strata emerged from the interviews. Highlights, in the Informational category, the dimension "the use of information obtained by counter-referral for continuity of care"; in the Relational category, the dimension "the importance of professional-patient bonding", and in the Managerial category, "the use of network mechanisms for effective care".* ***Conclusión:*** *la contrarreferencia se evidenció como una estrategia de continuidad del cuidado por parte de los dos grupos investigados, capaz de brindar apoyo para promover el cuidado eficiente de la puérpera. Sin embargo, existe la necesidad de optimizar los instrumentos estandarizados de contrarreferencia, haciendo efectivo el proceso en la red de salud.*

Descriptores: *Continuidad de la Atención al Paciente; Regulación y Fiscalización en Salud; Administración de los Servicios de Salud; Servicios de Salud Materno-Infantil; Enfermería.*

INTRODUCTION

Service in the Brazilian Unified Health System (Sistema Único de Saúde – SUS, Portuguese acronym) is structured through the Healthcare Network (Rede de Atenção à Saúde – RAS, Portuguese acronym), which provides comprehensive, non-fragmented healthcare based on preventive, curative and rehabilitation actions, with a view to continuity of care[1,2].

The continuity of care, in turn, must be perceived by healthcare users with observation of their needs and preferences in a progressive, organized, uninterrupted and individualized way[3]. It is classified into three categories or types: informational, relational and managerial, each one of them with different dimensions.

The "Informational continuity of care" has two dimensions. The first is "transfer of information" which deals with the availability of patient information to providers or health organization. The other is "accumulated knowledge of patient", which provides an understanding patients' values and preferences, and how these factors will influence care planning[3,4].

The "Relational continuity" comprises the following dimensions: "ongoing patient-provider relationship", which deals with the therapeutic relationship firmed through an implicit contract between the parties, whose the nature depends on duration and type of care involved; and "consistency of personnel" involves the manutention of the same team of caring, that allows the establishment of trust between patients and the team, respecting their beliefs and individuality[3,4].

Finally, "Management continuity" includes the dimensions "consistency of care" and "flexibility". The first deals with the coordination of healthcare, with the guarantee of care being received in a cohesive and complementary way, allowing the interaction of the multidisciplinary team within the service and between different services; and the last, in which versatility should be used in the provision of care when necessary[3,4].

These categories and respective dimensions related to continuity of care must be established within the hospital and between institutions at different levels of healthcare. However, situations of discontinuity in healthcare persist in the different lines of care[5-8]. Difficulty in accessing information is an example of the fragmentation of care provided to patients, caused by inefficiency or lack of formal communication between levels of care[9].

Some care transition strategies are used to reduce this gap, such as: discharge planning, counter-referral, patient education and promotion of self-management, safety in the use of medications, assertive communication of information, seeking to implement the concept of continuity of care, among which the counter-referral process stands out[10,11].

Counter-referral is a strategy that brings together a set of administrative and care activities defined in the referral of users of a health facility with greater technological density for the return of these users to their health unit of origin in order to guarantee the continuity of care[12,13].

In this perspective, the Discharge Management Service was implemented in a university hospital in Southern Brazil. This service performs management of cases and counter-referrals to other levels of the RAS, for all areas of the hospital, including the line of obstetric care.

Although this line of care has a differentiated clientele, since most of this population does not have a

chronic health condition, continuity of care is necessary to prevent maternal and child morbidity and mortality and increase the quality of life in society[13].

In this context, the aim of this study is to evaluate counter-referral as a strategy for the continuity of care for women and newborns from a usual-risk maternity hospital to primary healthcare.

METHODS

This is an exploratory qualitative study of professionals and women assisted in Municipal Health Units (Unidades Municipais de Saúde – UMS, Portuguese acronym) that have a referral link with a usual-risk maternity hospital in the city of Curitiba (state of Paraná, Brazil). Curitiba has 111 UMS, of which 47 are referral units for the studied maternity. Among these, 45 received a counter-referral in the year the study was conducted.

Nurses from these UMS participated in the study, as well as puerperal women served at the referral maternity, who were counter-referred to these units. The selection of participants was based on a database provided by the service. Women were contacted according to the sequential order of the spreadsheet provided, and nurses were selected based on the UMS that received the greater number of counter-referrals in 2019. The inclusion criterion for nurses from the UMS was having received at least three counter-referrals from the maternity during the year 2019. Nurses on work leave for any reason were excluded. Inclusions criteria for puerperal women were: age equal to or greater than 18 years and who had their counter-referral discharge authorized by the Maternity Discharge Management Service. Puerperal women not residing in Curitiba were excluded.

After searching the maternity hospital database, telephone contact was made with participants of both groups informing the purpose of the interview and the work and scheduling the date of the interview. The Informed Consent was presented at the time of the interview and signed by participants.

The study was carried out in two stages: in the first, from 2 September to 3 November, 2020, eight UMS nurses were interviewed; in the second, from 15 October to 10 November, 2020, six women that were counter-referred to the UMS were interviewed. All interviews were conducted by the same researcher.

Interviews were audio recorded and transcribed in full. The steps of Braum and Clarke[14] were followed in the thematic analysis, i.e., familiarization with data; coding; search for patterns or themes; review of themes; naming of themes and production of the research report in a deductive way guided by the researcher's theoretical interest, with pre-defined themes and sub-themes according to the theoretical framework of continuity of care[4].

Thus, the discourse of participants was stratified according to the themes: informational, relational and managerial continuity, and classified according to subthemes (dimensions of continuities) and according to speeches of puerperal women and nurses. Excerpts from interviewees' speeches were indicated as N for nurses and W for women added by a sequential number to preserve the identity of participants.

The project was approved by the Research Ethics Committee of the Complex Hospital de Clínicas of the Universidade Federal do Paraná and by the Ethics Committee of the Municipality of Curitiba (Certificate of Presentation of Ethical Appreciation, Portuguese acronym – CAAE: 14087619.4.0000.0096; opinion number 4.161.855).

RESULTS

Nurses' age ranged from 27 to 54 years. Seven were female and one was male, and the average time working in primary care was seven years.

Puerperal women were aged 18-45 years. Two of them studied until primary school, three completed secondary school and one attended higher education, but did not complete it.

The speeches of nurses and puerperal women originated 26 strata related to different categories of continuity of care and their dimensions.

Evaluation of the types of continuity of care and their dimensions in the process of counter-referral from the reference maternity to basic health units

Ten strata of discourses mentioning the "Informational continuity" category were identified. This category presents the following dimensions: "transfer of information" and "accumulated knowledge of patient" (Figure 1).

Five strata were identified (Figure 2) in the "Relational continuity" theme and the respective dimensions ("ongoing patient-provider relationship and "consistency of personnel").

Eleven strata were identified in the speeches that referred to dimensions of the "Management continuity" category ("consistency of care" and "flexibility"), as shown in Figure 3.

Figure 1 - Dimensions of "Informational continuity", the respective discourse strata and examples of speeches, Curitiba, PR, Brazil, 2021

Subtheme (dimensions)	Strata	Examples of speeches
Transfer of information	1. Information obtained is relevant and helps in care.	*[...] so, we know what's been done, for us it is important... this is very important for us to determine the sequence, you know, of treatment [...]. (N4)*
	2. Counter-referral brings previously unknown information, women were unable to reproduce the information in full.	*[...] sometimes the puerperal woman cannot give some information about the health condition or events there [...].* (N9)
	3. Information is important for continuity of care.	*The strong point is the continuity of follow-up, [...] it obviously promotes continuity.* (N10)
	4. Description of the counter-referral can be improved.	*[...] because the counter-referral is quite summarized, [...].* (N10)
	5. Lack of knowledge of primary care about events in the Maternity unit show gaps in counter-referral.	*[..] I was the one looking for the medicine, I went there to inform that he had been born.* (W2)
	6. Lack of information systems integration.	*[...] I have no knowledge about their access via electronic medical records, you know, of the pregnant woman, if they have the entire report, that is important [...].* (N10)
	7. Limited transfer of information from the professional to the user.	*[...] because the physician assisting us doesn't care a lot about that, your doubts [...].* (W3)
Accumulated knowledge of patient	8. Guidance based on prior knowledge.	*I was already aware that her heartbeat was dropping... I wanted a natural delivery, but they warned me it would have to be a cesarean section [...], so, at this moment, even though I wanted a natural delivery, I opted for my health and that of the baby's.* (W4)
	9. Need for guidance.	*[...] many pregnant women also go to the hospital for anything, [...] we are intensifying the guidelines for pregnant women [...].* (N11)
	10. Perception of one's health situation.	*[...] finally, came the end of my pregnancy, I was 41 weeks, as I saw that my baby, that I wasn't feeling any pain, or anything, I decided to do a private ultrasound, I paid for it, and when I did the ultrasound, the physician said I was leaking fluid [...].* (W5)

Note: N: nurse; W: woman.

Figure 2 - Dimensions of "Relational continuity", the respective discourse strata and examples of speeches, Curitiba, PR, Brazil, 2021

Subtheme (dimensions)	Strata	Examples
Ongoing Patient-provider relationship	1. Counter-referral as an alert tool for special or risk situations.	*"[...] The counter-referral is very important so that we perform a real follow-up of the patient... this adds a very important value [...]. They often leave the maternity with requests and referrals, treatments, that you need to reorient, check if it has been scheduled [...] there is a whole monitoring and care.* (N11)
	2. Impaired physician-patient relationship, lack of trust.	*"[...] he doesn't treat you with excellence ... I searched the unit; I didn't get excellent care ... I wanted to change my physician, I didn't want him anymore, [...].* (W3)
	3. Building a bond with maternity professionals.	*[...] so, the differential of the maternity hospital where they have it, they offer full embracement, they listen to you, all the exams are done, you are only released after you are really well, [...] there was a nurse who ... And there was the GO [...] the service was excellent.* (W3)
Consistency of personnel	4. Counter-referral as a tool that favors resolution in health.	*I guess it's this interaction, really, because we manage to provide care, how can I say it, more resolving for some cases, you know [...].* (N6)
	5. Physicians and nurses are a reference for discharge.	*The physician and explained everything, it was the physician, and I also had a lot of assistance from the nurse".* (W3)

Note: N: nurse; W: woman.

Figure 3 - Dimensions of "Management continuity", the respective discourse strata and examples of speeches, Curitiba, PR, Brazil, 2021

Subtheme (dimensions)	Strata	Examples
Consistency of care	1.Perceived improvement in multidisciplinary and interinstitutional relationships.	*[...] the path becames more open, you know, the dialogue, easier. (N8)*
	2. There was no perceived change in the multidisciplinary and interinstitutional relationship.	*No, actually I don't feel this direct difference [...]. (N10)*
	3. Need for the systematic use of counter-referral throughout the pregnancy-puerperal cycle.	*[..] this return that was done there in an emergency, it is also important for us and not everyone knows how to explain it [...], this counter-referral, not only in the postpartum period, but in the antenatal period as well, [...]. (N4)*
	4. Fragmentation of care, indicating weaknesses in counter-referral.	*[...] there were several exams that I could have done in the first trimester, and I didn't because they didn't pay attention to whether I had already done it or not, when the maternity ward asked for the exams and noticed that I hadn't done, [...]. (W3)*
	5. Access to interinstitutional dialogue is not perceived as an element resulting from the implementation of the counter-referral.	*[...] with the hospital, we have access, free access, both of them to us, and us to them. [...] not specifically by this counter-referral.* (N11)
	6. Time reduction in referrals.	*[...] we manage to take action more, I guess, faster, more correctly, [...].* (N6)
	7. Continuity provides a differential in care.	*I think the assistance is different, you know, patient care, [...].* (N11)
	8. Problems caused in the continuity of care by the COVID-19 pandemic.	*[...] it was a bit messy because of the pandemic, she had her first appointment after 35 days, you know!* (W6)
	9. Delay in performing the counter-referral.	*[...] many times I already know about the delivery before receiving the counter-referral [...]. So, when the counter-referral arrives, sometimes they have already passed, they have already had the consultation, it does not get in time, you know?* (N9)
Flexibility	10. Flexibility is not perceived in the care plan.	*No, actually I don't feel this direct difference [...]* (N10).
	11. The user's active search for primary care after missing the puerperal consultation.	*In fact, I had a consultation, right, when he was born, I didn't go, they got in touch, you know* (W1).

Note: N: nurse; W: woman.

DISCUSSION

With regard to "Informational continuity", in the information "transfer dimension", the existence of breaks or gaps was observed, notably in obtaining information about previous clinical conditions. If absent, these are considered as unknown by professionals. This data reinforces the need for strategies related to improving the exchange of information during care transfers, with the standardization of structure in verbal and written content[6]. In this sense, counter-referral can make a positive contribution, since information is the guiding principle for care transfers within hospitals and between RAS points[5], it helps in care and promotes continuity of care[15].

Knowing the details of the hospitalization is fundamental and allows the individualization of the next information, such as the normal changes expected in the postpartum period, the care of the woman and the newborn, the return of sexual intercourse, the possible complications in the postpartum period, as well as the beginning of the discussion of contraceptive plans[13]. These decisions must be based on experiences of the user and the professional, which generate an accumulated knowledge that can be an important ally when developing the care plan, and providing better adherence to the guidelines given[10].

The investment in knowing this information makes the professional perceive the needs and perspective of the patient served. In the case of maternity, the woman, the baby and their family, increasing the capacity for bonding, and scrutinizing small details for each service,

respecting human, cultural and social diversity, overcoming the difficulties faced by women[7].

Considering that the levels of care proposed by the RAS do not have a relationship of subordination between them, and networking brings the possibility of offering services in a continuous, comprehensive manner, it is necessary to hold professionals accountable at the most and least dense levels, so that they make referrals and counter-referrals, avoiding failures associated with lack of knowledge, optimizing shared care[16].

The study points to evidence that health education during antenatal care is deficient, requiring greater investment by the multidisciplinary team in the development of initiatives that promote women's literacy about the expected events (or not) in their pregnancy. It is expected that professionals develop communication skills that enable the promotion of care and establish a good relationship between provider and user throughout the pregnancy-puerperal cycle[10,15].

The relationship between professional and patient is the basis of all treatment and directly implies on health and adherence to clinical recommendations[17]. As this patient-provider bond will directly interfere with patient satisfaction, trust is an essential element for the success of this relationship; trust in the professional, the institution and the health system. When this feeling is established, a connection for future situations is developed[4,18]. When this felling occurs, the ongoing patient-provider relationship is developed for future situation[4,18]. This bond allows explain health professionals to advocate on behalf of the patient, as by knowing their beliefs and wishes, combined with their health needs, they can advise on the best decisions to maintain their health[18].

Despite this unequivocal importance, the present study pointed out gaps in relation to this dimension of continuity of care. Some women were unable to establish this bond with the professionals who assisted them during antenatal care. They mentioned situations such as the lack of clarification of their questions and inaccurate information, factors that can be considered as causing the breakdown of the patient-provider trust[18].

The feeling of little appreciation of demands in primary care reported by women undermines the relationship between professional and patient, making that sensitive information is hidden and limiting the care provided. The use of counter-referral can highlight situations previously not perceived during antenatal care, such as vulnerability, problems in the family bond, substance abuse. This represents essential information for professionals, which will serve as an alert for the need to strengthen the relationship with the woman and family[14].

In the international scenario, the main complaints mentioned by patients regarding the break of trust are also related to the lack of bonding and the difficulty in managing care transitions[18], as in the present study, suggesting that these barriers represent global difficulties. Added to this is the lack of respect for values, difficulty in coordinating care and communicating with providers, in relation to lack of physical comfort, emotional support and involvement of family and friends[18].

On the other hand, part of women reported the presence of the "ongoing patient-provider relationship" dimension during their hospitalization in the maternity ward, even with the limited contact time of approximately 48 hours. Puerperal women reported that this time was enough to establish a relationship of strong trust.

Public policy for this line of care establishes priority, dignified and humanitarian assistance, and recommends that professionals are trained to consider these as inalienable citizenship rights[17]. In this context, adequate preparation for discharge and measures regarding counter-referral for continuity of care are expected.

Participants identify physicians and nurses as professionals responsible for hospital discharge. Nurses are usually responsible for the discharge flow, developing a central role in the individualized discharge plan[8,13,14]. The perception that both professionals are linked to this procedure leads us to consider that care coordination is integrated between professional categories, which can strengthen discharge planning, and thus increase women's quality of life and prevent further hospitalizations[19].

"Management continuity" is especially important for complex clinical conditions or those requiring multiple professionals to work with interconnected proposals, providing care technologies with the aim of integrating the care provided[20].

In this context, the successful relationship between professionals from different areas of health is a highlighted theme, since it allows significant exchanges between providers. Collaboration is one of the important requirements for achieving a good relationship and this union of knowledge favors the resolution of patients' problems by promoting comprehensive care[21]. According to professionals interviewed, the use of counter-referral favored the multidisciplinary and interinstitutional relationship, highlighting proximity and communication, factors they mentioned as important in the coherence of care.

Another fact that collaborates with the coherence of care is the routine use of counter-referral during antenatal care, childbirth and the puerperal period, although this action was not observed in this study. This finding corroborates the results of another study conducted in different places in Brazil, in which the lack of counter-referral was shown as a factor that may generate discontinuity of care and harm the quality of antenatal

and postpartum care, especially in women and babies at higher risk, as when returning to PHC they may be exposed to complications[22].

The use of the referral and counter-referral strategy represents a normative device that will provide the user with access to care levels according to the needs of each one of them, combined with the right to health established in the Brazilian Magna Carta (Brazilian Constitution). Access to health is the right of every citizen and must be perceived in a transparent manner by the entire population[23].

The optimization of care through the use of counter-referral guarantees adequate access to the care needs of each woman or newborn, fulfilling its role of promoting continuity of care[13]. When care is provided in a timely manner to meet users' needs, complications are avoided[23]. In turn, situations of delay in the delivery of the counter-referral, an event mentioned by some professionals, should be avoided, as it can cause significant damage to the treatment and lives of patients.

The interviewed women perceived fragmentation in the presented context during the change of care location, when there were discordant behaviors between professionals of the maternity and those in primary care. If there is no close action between the levels of care in the health network, the guarantee of comprehensiveness is impaired, leading to a delay in access and contributing to the potentialization of complications, reducing the quality of care provided[23]. Strategies such as counter-referral try to overcome the existing fragmentation in the current care model[9].

Data collection for this study was hampered by the COVID-19 pandemic due to the need for social isolation and the reorganization in the work process of Basic Health Units. Thereby, the data collection procedure had to be ended with a lower number of participants than desired in the initial planning, which may constitute a limitation of the study. The studied maternity was transferred to another physical space, where there was a change in work processes, and the use of counter-referral was suspended, as it was necessary to relocate professionals responsible for this activity to critical places of direct patient care during the pandemic.

Despite these limitations, this study brings elements that contribute to expand the discussion of the concept of continuity of care.

FINAL CONSIDERATIONS

The counter-referral from a usual-risk maternity hospital to primary health care is a strategy that promotes continuity of care for women and newborns. Strengths and weaknesses are present in the three categories: Informational, Relational and Managerial. Among the strengths in the Informational category, the dimension "transfer of information" stands out; in the Relational category, the dimension of "consistency of personnel of professional. In the "Management continuity" category, the strengths are not as evident as the weaknesses and, in this aspect, the consistency of care dimension stands out, more specifically the delay for the performance of the counter-referral.

FINANCING

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CONFLICT OF INTEREST

None.

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AUTHORS' CONTRIBUTIONS – CRediT

LSL: conceptualization; data curation; formal analysis; funding acquisition; investigation; methodology; resources; validation; visualization; writing – original draft and writing – review and editing.

EB: conceptualization; data curation; funding acquisition; methodology; project administration; resources; supervision; validation; visualization; writing –original draft and writing – review and editing.

OBMS: conceptualization; methodology; resources; validation, visualization; writing – original draft and writing – review and editing.

AMP: validation; visualization; and writing – review and editing.

THT: validation, visualization; and writing – review and editing.

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